National Justice Project

NJP POSITION STATEMENT:

Health Justice

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Contact

University of Technology Sydney, National Justice Project, CB01.07,
P.O. BOX 123, Gadigal Country, Broadway, NSW 2007
T: +61 2 9514 4440 E: info@justice.org.au
W: www.justice.org.au FB: https://www.facebook.com/NationalJusticeProjectAu/
Twitter: https://twitter.com/NJP_Au
Instagram: https://www.instagram.com/nationaljusticeproject_au/?hl=en
LinkedIn: https://www.linkedin.com/company/national-justice-project/mycompany/

The National Justice Project

The National Justice Project ('**NJP**') is a not-for-profit human rights legal and civil rights service. Our mission is to fight for justice, fairness and inclusivity by eradicating systemic discrimination. Together with our clients and partners, we work to create systemic change and amplify the voices of communities harmed by government inaction, harm and discrimination.

The NJP creates positive change through strategic legal action, supporting grassroots advocacy, collaborative projects, research and policy work and practice-inspired and catalytic social justice education. Our focus areas include health justice, specifically for persons with disability and First Nations communities; racial justice, challenging misconduct in policing, prisons, judicial and youth services; and seeking justice for refugees and people seeking asylum. We receive no government funding and intentionally remain independent in order to do our work. We therefore rely on grassroots community, philanthropic and business support.

Acknowledgement of First Nations Peoples' Custodianship

The National Justice Project pays its respects to First Nations Elders, past and present, and extends that respect to all First Nations Peoples across the country. We acknowledge the diversity of First Nations cultures and communities and recognise First Nations Peoples as the traditional and ongoing custodians of the lands and waters on which we work and live.

We acknowledge and celebrate the unique lore, knowledges, cultures, histories, perspectives and languages that Australia's First Nations Peoples hold. The National Justice Project recognises that throughout history the Australian health and legal systems have been used as an instrument of oppression against First Nations Peoples. The National Justice Project seeks to strengthen and promote dialogue between the Australian legal system and First Nations laws, governance structures and protocols. We are committed to achieving social justice and to bring change to systemic problems of abuse and discrimination.

National Justice Project

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EXECUTIVE SUMMARY

National Justice Project position on Health Justice

The National Justice Project ('**NJP**') believes that everyone has the right to the highest attainable standard of healthcare delivered in a manner that is culturally safe, dignified and respectful, without discrimination or prejudice based on legal status, culture, ethnicity, religion, gender, disability, socio-economic status, geography, or sexuality.

Far too often in Australia, people are denied access to quality healthcare due to racial discrimination, their country of origin and visa status, or due to a physical or intellectual disability. The Australian Government has grossly failed to discharge their obligations time and again. This ongoing failure to provide adequate healthcare is a crisis that needs to be remedied with urgency.

Racism and other forms of discrimination are an endemic problem in Australia and these prejudices permeate into our health system resulting in the failure to deliver essential health services to communities which are susceptible to systemic oppression. The failure of successive Federal State and Territory governments to provide culturally safe and adequate healthcare is harmful and at times fatal. There is a growing and substantial body of evidence to establish racism, discrimination and disempowerment as determinants of poorer health outcomes.[1]

National Justice Project approach to Health Justice

The NJP's Health Justice, Racial Justice and Just Systems programmes challenge systemic discrimination in the health system by securing legal and policy reforms to ensure equitable access to quality, dignified, trauma-informed and culturally safe healthcare. The NJP supports clients in their pursuit of justice through legal processes including litigation, conciliation and complaints. We also pursue health justice through education programmes, advocacy and collaborative projects. We contribute to public debate, awareness and make powerful submissions to public inquiries to draw the attention of decision-makers to the systemic causes of health care discrimination and pressure governments to implement the recommendations of coronial inquests and parliamentary inquiries through petitions and open letters. We support our clients to tell their stories, helping to educate and raise awareness in the wider community and inspire others to fight for justice.

We work with a range of community organisations to address individual, institutional and systemic racism in the health, justice and social service systems. We are an active member of the Partnership for Justice in Health; we work closely with the Queensland University of Technology Indigenist Health Humanities project; we have developed an Aboriginal Patient Advocacy Training programme with the Aboriginal Health Council of Western Australia (ACHWA) and the Health Consumers' Council of WA (HCCWA); and we work closely with Deadly Connections to deliver the Bugmy Justice Project.

In partnership with Larissa Behrendt AO, we have created a number of digital roundtables with a range of expert panellists on the topic of Health Justice for First Nations people, including: Fighting for the Rights of

First Nations People with Disabilities in the Justice System; Spotlight on the NSW report into First Nations deaths in custody; and Exploring health justice beyond the courtroom.

Working with a range of stakeholders from the legal, community and advocacy sectors, and with support from our partners, donors and sponsors, we delivered our inaugural *Law Hack 2021: Disability Justice* in a unique event where participants worked in teams to solve some of the most challenging problems and injustices facing people living with disability. A panel of judges selected a new emergency services branch to support people with disability (and others requiring specialist support) and divert them from police and the criminal justice system as the winning pitch.

Together with the Jumbunna Institute for Education and Research, we have developed *Call it Out*, an online register to record instances of personal or systemic racism towards First Nations peoples and promote anti-racist policy and practices, and our Tech4Justice programme aims to create technological solutions to enable users to make complaints, navigate the complex complaint pathways and access support, as well as gathering evidence to inform advocacy strategies driven by communities affected by discrimination to drive systemic change.

Many of our clients have been directly impacted by negligent and inadequate medical treatment, often as a result of discrimination. We represent individuals and families of loved ones who have been harmed or have died because of poor or discriminatory attitudes in medical treatment and facilitate legal action and complaints against government, health and custodial institutions that have failed in their duty to provide quality and respectful healthcare. We are motivated and informed by the strength and experiences of our clients and their communities and it is from this perspective that we present the NJP's Position Statement on Health Justice.

PRIORITIES & RECOMMENDATIONS

Universal Healthcare Principles

1. The Australian Government has an obligation to ensure all people receive the highest attainable standard of healthcare, irrespective of legal status, culture, ethnicity, religion, gender, disability, socio-economic status, geography, or sexuality.
2. People in police custody, prisons, youth detention and immigration detention have the right to receive adequate healthcare at a standard equitable to that available in the community, without discrimination.
3. Standards of equitable healthcare must be proportionate to the needs of the individuals and communities it serves.

Healthcare that is culturally safe and free of discrimination

4. Healthcare should be delivered in a culturally safe, anti-racist, non-discriminatory and trauma-informed manner.
5. Improved access to healthcare services is needed, particularly in rural, regional and remote areas.

6. Community-defined, objective and meaningful measurements of institutional racism and implicit bias is needed, with the results published and utilised to implement evidence-based reforms.

Healthcare for First Nations people

7. First Nations people should receive the highest attainable standard of healthcare. At a minimum, the standard should be equitable to that which is enjoyed by the rest of the community.
8. First Nations people have the right to receive culturally safe, dignified, and respectful healthcare and it is incumbent on the Australian Government to ensure this right by:
    a. Acknowledging that explicit systemic racism exists within the health system.
    b. Acknowledging the deleterious impacts institutional and individual racism has on First Nations peoples' access to and engagement with health systems.
    c. Applying anti-racist and race critical approaches to the health agenda, in partnership with First Nations communities, researchers, organisations and practitioners to address the disparate and harmful health outcomes for First Nations people and to achieve justice in health by enabling a health system free of racism.
9. Acknowledging that systemic racism exists within the health system, healthcare should be provided in a manner that appropriately services the cultural and social needs and expectations of the community, especially where that community is First Nations. Such an approach should include:
    a. Enhancing the employment and retention of First Nations healthcare professionals.
    b. Enhancing resourcing and support for Aboriginal Community Controlled Health Organisations (ACCHOs).
    c. Strengthening the Aboriginal Health Liaison Officer programme and supporting the development of community-led culturally appropriate patient advocacy opportunities.
10. Urgently implement and provide resources for the implementation of the recommendations of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC)[2] regarding health care, social welfare and
11. Where a First Nations death occurs in custody or in or after health care, the recommendations of the RCIADIC regarding coronial inquests should be implemented.[3]

Healthcare for asylum seekers and refugees

12. It is incumbent on Federal, State and Territory governments to ensure that safe and adequate healthcare is made available to all, without discrimination, including on the grounds of their citizenship and residency status.[4]
13. Healthcare should be delivered in a manner that is culturally appropriate and trauma informed, with special consideration to physical and mental health needs proportionate to the harmful conditions created and exacerbated by detention.
14. Immigration detention should only be applied or considered as a last resort[5] with temporal limits in place when detention is applied.
15. All mandatory and indefinite immigration detention policies should be repealed.
16. Asylum seekers and refugees detained in immigration and third country processing facilities or remaining in third countries post processing, should receive appropriate healthcare without discrimination at a standard equivalent to that which is enjoyed by the rest of the Australian community regardless of their citizenship and residency status, including full access to the Medicare Benefits

Scheme (Medicare), the Pharmaceutical Benefits Scheme (PBS) and the National Disability and Insurance Scheme (NDIS).

17. Asylum seekers and refugees should receive appropriate healthcare without discrimination at a standard equivalent to that which is enjoyed by the rest of the community regardless of their citizenship and residency status, including full access to Medicare, the PBS and the NDIS. Adjustments to living arrangements should be made for those Asylum seekers and refugees with a disability.
18. Enhanced resourcing and supports are needed to improve asylum seeker and refugee access to healthcare services, including mental health and disability services.
19. Asylum seekers and refugees with disability have the right to receive the highest attainable standard of healthcare without delay or discrimination.
20. The *Migration Act 1958* should be amended to extend the operation of s 4AA to include persons with disabilities.[i]

Healthcare for people on temporary visas

21. Enhanced resourcing and supports are needed for improved access to healthcare services for adults and children on temporary visas, including mental health and disability services.
22. Efforts should be made to improve the NDIS plan to provide community-based, holistic, compassionate and responsive health and support services for individuals with disability.
23. The ten-year residency minimum for the Disability Support Pension should be abolished, or at least substantially reduced.
24. Improved access to essential support services is needed for individuals with disability on temporary visas, especially children.

Healthcare for people with a disability

25. People with disability should receive the highest attainable standard of healthcare. At a minimum, the standard should be equitable to that which is enjoyed by the rest of the community.
26. People with disability have the right to receive culturally safe, dignified, and respectful healthcare and it is incumbent on the Australian Government to ensure this right by:
    a. Acknowledging that explicit systemic discrimination exists within the health system.
    b. Acknowledging the deleterious impacts institutional and individual discrimination has on people with disability's ability to access and engage with health systems.
    c. Applying anti-ableist approaches to the health agenda, in partnership with disability groups, communities, researchers, organisations and practitioners to address the disparate and harmful health outcomes for people with disability and to achieve justice in health by enabling a health system free of discrimination.
27. Acknowledging that systemic discrimination exists within the health system, healthcare should be provided in a manner that appropriately services the cultural and social needs and expectations of the community, especially disabled individuals and groups. Such an approach should include:
    a. Enhancing the employment and retention of healthcare professionals with disability in a manner that is sensitive to their needs.

[i] Section 4AA of the Migration Act provides that 'a minor shall only be detained as a measure of last resort'.

b. Resourcing and support for disability advocates and groups.

Healthcare in the justice system

28. Governments must ensure that safe and adequate healthcare is made available to all, without discrimination, including on the grounds of their legal situation.[6]
29. People in custody (including people in police custody, prisons and youth detention facilities) should receive access to healthcare at a standard equivalent to that provided in the community, including full access to Medicare and PBS and NDIS services.
30. Enhanced resourcing and supports are needed to fund and provide appropriate and culturally safe healthcare to people in custody, delivered by culturally appropriate services with such care to include holistic health care, mental health care, psychosocial supports, disability care, healing and rehabilitation.
31. Governments should move to apply imprisonment as a last resort, and instead prioritise rehabilitation and healing principles for First Nations adults and children.[7]
32. Children are entitled to special protection due to their age and do not belong in prisons. The minimum age of criminal responsibility should be raised to at least 14 years for all offences consistent with medical and scientific evidence pertaining to child and adolescent neurodevelopment, and in line with international standards.
33. Police-led responses to people experiencing mental health crises and exhibiting cognitive and psychosocial disability remain inadequate and ineffective and should be replaced with community-based, compassionate, holistic and responsive social and health services and supports.
34. Amend the *Coroner's Act 2009* (NSW) to expand the scope of coronial inquests to mandate that coroners examine and make recommendations relevant to systemic issues including quality of care, treatment and supervision of people in custody.
35. Urgently implement and provide resources for the implementation of the recommendations of the RCIADIC that relate to healthcare and subsequent coronial inquests into First Nations deaths in custody that relate to healthcare.

Healthcare and intersectionality

36. Governments must ensure that safe and adequate healthcare is made available to all, without discrimination or prejudice.
37. Discrimination and prejudice in healthcare can be intersectional and care should be taken to ensure that issues with and improvements to healthcare that cross over all patients, notwithstanding their legal status, culture, ethnicity, religion, gender, disability, socio-economic status, geography, or sexuality are implemented universally.

THE JUSTIFICATION

Legislative, policy and service issues

Current legislation and policy instruments are inadequate to ensure all people have equitable access to healthcare. This is particularly true for First Nations people, asylum seekers and refugees, people from

culturally and linguistically diverse (CALD) backgrounds, people with disability (including physical, cognitive and psychosocial) and people in custody (including police custody, prisons, and youth detention). Lately, these inadequacies are exemplified in State, Territory and Federal Governments' management of the COVID-19 pandemic through which the health and safety of these communities are further jeopardised as governments continue to negate their obligations to meaningfully engage with these communities and prioritise access to vaccines, information, support and adequate healthcare, and management strategies for social distancing and self-isolation in a manner that is trauma informed and culturally safe.[8]

Healthcare that is culturally safe and free of discrimination

The concept of cultural safety is drawn from the work of Māori nurses in New Zealand and can be defined as: "An environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening".[9]

In health settings, culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.[10]

The research identifies a clear link between racism and poorer mental health, including depression, anxiety and psychological stress, in addition to poorer general and physical health.[11, 12] In Australia, racism and discrimination has permeated our health system, resulting in the failure of the healthcare system to deliver essential health services to individuals and communities most vulnerable to systemic neglect and oppression. This is particularly true for First Nations peoples,[13] asylum seekers and refugees,[14] people from culturally and linguistically diverse backgrounds[15] people with physical, cognitive and psychosocial disability,[16] and people experiencing homelessness, income insecurity and poverty.[17]

Continued experiences of racism and inadequate care can lead to an expectation of discrimination resulting in subsequent avoidance of situations and institutions. First Nations disability expert and researcher, Worimi man, Dr Scott Avery has described this concept as 'apprehended discrimination' – a rational fear of discrimination, based on experience, which can lead to an avoidance of situations in which a person would be further exposed to discrimination.[18]

Policy initiatives continue to fail to address systemic racism. For example, the Australian Human Rights Commission's call on the Federal government to support the implementation of a national 'Anti-Racism Framework',[19] fails to define key concepts such as race and racism while the National Aboriginal and Torres Strait Islander Health Plan's 'vision of a health system free of racism'[20] also fails to define concepts of race and racism and sidesteps examining how race and racism operates in the Australian healthcare system.[21] Professor Chelsea Watego et al highlight that inherent in these initiatives is the assumption that the prejudices or attitudes of *individuals* adversely affects the health behaviours of First Nations people resulting in the failure of the health system to provide equitable and appropriate health care, rather than acknowledging that systemic racism is the direct result of the "ongoing impact of dispossession and colonialism, the structuring impact of discriminatory government policies and practices and the prevalence and multiple expressions of racial violence".[22]

Universal Healthcare Principles

Governments have a responsibility to ensure the highest attainable standard of health and wellbeing of their population through the provision of adequate health services and social measures, an internationally recognised and fundamental requirement.[23]

Healthcare for First Nations people

The experiences of First Nations people and healthcare cannot be properly considered without acknowledgement of the historical context in which health has operated. Australia as a colony was built on the social construction of race as a divisive power and we do not minimise its power by ignoring it.[24] Many regional hospitals were segregated, some as late as the 1960s and many First Nations peoples are aware of and continue to feel the impacts of this history.

As mentioned above, governments have a responsibility to ensure the highest attainable standard of health and wellbeing of their population through the provision of adequate health services and social measures, an internationally recognised and fundamental requirement.[25] The *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP) specifically provides that First Nations peoples have the right to access health services free of discrimination.[26] Adequate healthcare provision for First Nations peoples requires culturally safe health services that are capable of providing safe and appropriate care.

A 2019 study found that 2 in 3 Australians hold negative views towards First Nations people.[27] These attitudes permeate into our health system and there is a growing and substantial body of evidence to establish racism, discrimination and disempowerment as determinants of poorer health outcomes.[28] Discrimination in the health system can present as either systemic barriers preventing or deterring individuals from accessing health care or as unsafe and inconsistent provision of health services.[29] Mainstream healthcare services must be made responsive, appropriate and culturally safe, and increased resourcing and support is required for Aboriginal Community Controlled Health Organisations (ACCHOs) to enable the delivery of culturally appropriate and adequate health services for First Nations peoples, including in prisons and youth detention facilities.[30]

The Interim Report of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability highlights the specific and disproportionate challenges First Nations peoples with disability living in regional, rural and remote areas face, including racism, ableism and neglect[31] and the need for First Nations people with disability to define what equitable access to adequate healthcare delivered in a manner that is culturally appropriate looks like.[32]

Healthcare for asylum seekers and refugees

The universal health care principles set out above apply to immigration detainees who often experience protracted and egregious abuse and neglect of asylum seekers and refugees. Many detainees having experienced trauma prior to arriving in Australia, are subsequently exposed to long-term, indefinite detention in sub-standard and confined conditions, with inadequate access to fresh food, clean water and social and health services, exposure to sexual, physical and psychological abuse and the onerous and lengthy process of establishing refugee claims.[33] These conditions contribute to poorer health outcomes in general and can exacerbate existing disabilities and trigger certain psychosocial disabilities, particularly in

children - people who are detained as children are likely to experience ongoing symptoms of post-traumatic stress disorder (PTSD) well into adulthood.[34]

The Australian government has a long history of neglecting the health and welfare of refugees and asylum seekers.[35] In March 2019, following the successful 'kids off Nauru' campaign, the Medevac Bill[36] allowed for the temporary transfer of patients in offshore detention to Australia for urgent medical assessment on the recommendation of two doctors and requiring a response by the Federal Health Minister within 72 hours.[37] Following its repeal in December 2019, [38] asylum seekers and refugees are left to languish in offshore detention facilities and must once again rely on sections of the Migration Act and the discretion of the Minister for urgent medical assessment and treatment.[39]

Healthcare for people on temporary visas

Asylum seekers who arrive in Australia by boat and subsequently determined to be refugees, are ineligible for the Subclass 866 Permanent Protection Visa, and can only be granted the 785 Temporary Protection Visa[40] or 790 Safe Haven Enterprise Visa.[41] Such distinctions deny migrant and culturally and linguistically diverse communities' access to much needed supports and services and contribute to poorer health outcomes. For example, the 785 Temporary Protection Visa and the 790 Safe Haven Enterprise Visa are temporary and do not entitle a person access to the National Disability Insurance Scheme (NDIS). The discriminatory treatment of refugees based on the date and manner of their arrival in Australia is punitive, inhumane and degrading, and violate international laws and obligations.[42]

Healthcare in the justice system

Access to equitable healthcare

The United Nations' *Standard Minimum Rules for the Treatment of Prisoners* (also known as the 'Nelson Mandela Rules'), establishes the minimum requirements for the treatment of all persons in prisons, youth detention, and remanded in custody.[43] The Nelson Mandela Rules are based on the overarching principle that "all prisoners shall be treated with the respect due to their inherent dignity"[44] and recognises that states are responsible for guaranteeing this right, including ensuring people in custody receive a standard of health care equitable to that which is available in the community, without discrimination; a right emulated in the RCIADIC recommendations.[45] Rule 22 (2) of the Nelson Mandela Rules states that "sick prisoners who require specialist treatment shall be transferred to specialized institutions or to civil hospitals"[46] and rule 82 makes it clear that those with mental health conditions should be "treated in specialized institutions under medical management".[47]

Domestically, Australian state and territory legislation provides that people in prison have the right to timely access to health care of equitable standard to that which is provided in the community,[48] also known as the 'equivalence of care' principle.[49] However, prisons and youth detention facilities are not adequately equipped to provide health services and supports to people with complex and multiple health, mental health, disability and rehabilitation needs. Instead, they often function as warehouses, particularly for people from lower socioeconomic circumstances, people with a history of trauma and substance misuse and people with mental health conditions and cognitive and psychosocial disability.[50]

The healthcare service and support needs of people in prisons and youth detention facilities are greater and more complex when compared to the healthcare needs of those in the outside community.[51] Despite the specialised needs of people in youth and adult prisons, the health, mental health, disability and rehabilitation services and supports available in prisons and youth detention facilities across Australia are grossly inadequate to meet the health demands of people in custody.[52] In 2020, across NSW adult prisons, 60,000 (11 per cent) of all scheduled health appointments in prison clinics were not attended, with the most common reason identified as 'patient unable to attend' followed by '[appointment] cancelled by Corrective Services NSW'.[53] To achieve the goal of equitable healthcare for people in custody, governments must urgently address the inadequate and inferior healthcare services available in adult and youth prisons[54] and the long waiting times for accessing what limited services are available[55] by mandating equitable access to proper medical staff and facilities within the community and the closure of all remaining prison hospitals, including Long Bay Prison Hospital in NSW.

The imprisonment rate in Australia is high by international standards.[56] Between 2003 and 2018 Australia had the third highest imprisonment rate rise within the OECD at 39 per cent, following Turkey and Columbia at 120 per cent and 46 per cent, respectively.[57] Nationally, between 2000 and 2008 Australia's imprisonment rate increased by 25 per cent, despite the rate of offending[ii] falling by 18 per cent over the same period.[58] Since 2006, the imprisonment rate for First Nations people increased by 35 per cent, compared with 14 per cent for the general population,[59] and the imprisonment rate for First Nations people is 13.3 times the rate of the general population.[60]

Despite Australia's domestic and international obligations, private and state managed prisons and youth detention facilities are not adequately servicing the healthcare needs of people in custody. The growing privatisation of prisons and prison services presents additional barriers to equitable and specialised health care for people in custodial settings. In Australia, private prisons and prison services, including healthcare and security services are operated by profit-driven multinational corporations, such as Serco, GEO Group, Broadspectrum, and G4S.[61] In 2019, the Queensland government announced that it would take over the contracts of two prisons – the Arthur Gorrie Correctional Centre operated by GEO Group and the Southern Queensland Correctional Centre operated by Serco – due to significant concerns following evidence of overcrowding, understaffing and excessive use of force by prison staff.[62] In the same year the South Australian government ignoring this warning granted Serco a contract to run the Adelaide Remand Centre.[63]

There is an inherent conflict of interest in contracting for-profit corporations to operate prisons and prison services on behalf of governments. Such conflicts are further exacerbated by a lack of financial incentive to reduce recidivism rates and a general disengagement with important public and not-for-profit service sectors, including mental health, disability, housing, employment and education.[64] Particularly when it comes to the delivery of healthcare, public and private prisons are not equipped to meet the health care needs of people in prison. Specialised health services should be made available to First Nations people and

[ii] The rate of offending is measured by the number of offenders proceeded against by police.

people with disability, and culturally safe and equitable health services made available to all in carceral environments whether privatised or publicly operated.

The *Health Insurance Act 1973 (Cth)* (Health Insurance Act) governs the national Medicare Benefits Schedule (Medicare), which includes the Pharmaceutical Benefits Scheme (PBS). Under section 19(2) of the 1976 amendment to the *Health Insurance Act),* Medicare benefits are not payable in respect of a professional service that has been rendered by, on behalf of, or under an arrangement with states and territories. In other words, because Medicare and PBS are managed and funded by the Federal government while custodial health services are managed and funded by individual State and Territory governments, it is argued that the responsibility for and costs associated with custodial healthcare falls on states and territories with the assumption that these governments are providing equivalent services to meet the healthcare needs of people in custody.[65] However, the exemption under section 19(2) of the *Health Insurance Act* provides discretionary powers to the Minister for Health to waive the Medicare exemption in rural and remote communities based on disadvantages in accessing health care services,[66] setting a general precedent for its use when there are inequalities in access to healthcare, such as in prisons, youth detention and immigration detention.

People with disability

People with disability are at greater risk of neglect, abuse and exploitation than people without disability. People with disability are less likely to report as victims of crime and when they do often encounter a compromised police response if they cannot provide a clear narrative of what occurred, are not believed or are dismissed as substance affected or wasting police time.[67] Women with disability are 4-10 times more likely to be victims of sexual violence and are far less likely to report the crime due to ableism and sexism in police responses.[68]

People with disability are disproportionately represented in Australia's criminal justice system: The result of an institutionalised process whereby certain acts and behaviours are criminalised and consequently policed and punished.[69] People with disability account for roughly 18 per cent of the Australian population while comprising about 29 per cent of the prison population.[70]

More than one in five First Nations children and almost one in two (48 per cent) First Nations adults live with disability and it is accepted that these figures are under-representative.[71] First Nations people with a disability are 14 times more likely to be imprisoned than the general population.[72] Since 1991, over 40 per cent of deaths in custody have involved First Nations peoples living with disability.[73] Incarceration also disproportionately impacts First Nations young people and young people living with disability. Where race and disability intersect, First Nations young people face a double disadvantage.

Many young people in the criminal justice system have complicated and multifaceted needs, including mental health and disability.[74] Incarceration in childhood is associated with increased risks of suicidality, depression, substance use, mental illness and cognitive and psychosocial disability.[75] Behaviours associated with cognitive and psychosocial disabilities such as attention-deficit/hyperactivity disorder (ADHD) and fetal alcohol spectrum disorder (FASD) are often misinterpreted as non-compliance or defiance[76] and met with punitive measures including excessive force, the use of physical restraints and prolonged solitary confinement.[77] Nationally, over 75 per cent of imprisoned children and young people are living with one or

more mental illness. The causal link between incarceration and poor mental health is well established, with some studies showing one third of incarcerated youth diagnosed with depression experienced its onset following incarceration.[78] Exposure to trauma and separation from home and community resulting from detention is known to further exacerbate mental health risks.[79]

Children are entitled to special protection due to their age. However, across Australia the minimum age of criminal responsibility is set at 10 years. Young children are vulnerable to the criminal justice system despite extensive evidence that the adolescent brain does not fully mature until a person is at least in their early 20s,[80] and that the prefrontal lobe, which accounts for criminal behaviour and offending, is the last area of the brain to mature.[81] All children should be supported through culturally appropriate community-based responses, with a focus on prevention, diversion and support rather than punishment. Children and young people with disability and complex needs, and their families are particularly vulnerable to the inadequate, discriminatory and culturally unsafe healthcare, education and other services available in custodial settings. Such measures are cruel, inhumane and degrading and violate international laws and obligations.[82]

The National Disability Insurance Scheme (NDIS), established under the *National Disability Insurance Scheme Act 2013,* was designed to give people with a 'permanent disability' greater choice and control over the support and treatment they receive. The range of supports and services available are limited for people in custodial settings. The NDIS does not cover services and supports that it considers to be the day-to-day responsibility of the justice system, including help with personal care, disability related health supports and medical supports related to other health conditions.[83] The limited services the NDIS does provide, such as prosthetic limb replacement, staff training and post-release capacity building supports,[84] are vulnerable to obstruction by the justice system which has the power to decide what supports can be delivered in a custody setting and can deny certain supports, such as assistive technologies, if they believe that it may be a risk to the participant or others.[85]

Access to the NDIS is also limited for people with psychosocial disability. Psychosocial disabilities are generally classified as 'non-permanent' and due to a lack of clear eligibility criteria around what constitutes a permanent psychosocial disability, most people with psychosocial disability do not meet the criteria of a 'permanent disability' and are therefore ineligible to receive related services and supports under the NDIS.[86] To complicate matters further all NDIS payments end whilst an individual is held in prison and they are often denied the programmes critical to their success and recovery. These complications are further exacerbated for people living in regional and rural areas where the NDIS is difficult to access and navigate due to limited services and supports available.[87]

Within the justice system, people with disability are at grave risk of verbal, physical and sexual violence as well as bullying and harassment.[88] Due to a lack of adequate and appropriate health services and trained staff, prison staff responses are often punitive, resorting to the use of physical restraints and prolonged solitary confinement and isolation.[89] By denying individuals in custody full access to supports and services under the NDIS, and by creating barriers for people with psychosocial disability to access the services and supports they need, the Australian government is not meeting its obligations to provide people in prison with healthcare and supports at an equitable standard to that which is provided in the community, in particular First Nations adults and children who are overrepresented among the prison population and who

historically have had negative experiences, if any, with existing disability and mental health support systems.[90]

Mental health and healing

The prevalence of people with mental illness in prisons is almost double that of the general population.[91]

People in prisons are 10 times more likely to report a history of suicidal ideation and suicide attempts, with the suicide rate being five times higher for men and twelve times higher for women in prisons when compared to the general population.[92] People in prison commonly suffer from depression, anxiety, drug and alcohol dependence, and post-traumatic stress disorder.[93] Prison staff do not have the skills and training to manage the specialised healthcare demands of people in prison living with mental illness and/or cognitive and psychosocial disability.[94] In many cases, this inadequacy results in prison staff using solitary confinement as a strategy to cope with behaviours of people with mental illness and disability rather than providing essential supports or treatments.[95]

In NSW, 50 per cent of all people in adult prisons have been diagnosed or treated for a mental illness, and 87 per cent of children in custody have a current or previous mental illness and/or cognitive or psychosocial disability.[96] The rates for First Nations adults and children are higher.[97] Across NSW adult prisons, demand for mental health care far exceeds service capacity, with patients being held in environments unsuitable for their needs.[98] In March 2021, at least 143 mental health patients were waiting to access acute or sub-acute mental health units, the average waiting period was 43 days, with 17 patients having wait times over 100 days.[99]

In Australia, persons with cognitive and psychosocial disability who are charged with a crime but found not guilty or 'unfit to stand trial' can be detained for indefinite and prolonged periods; a practice that can arbitrarily and unjustly detain people with disability.[100] The practice of indefinite and prolonged detention disproportionately affects First Nations people with disability.[101] In jurisdictions without fixed term sentencing,[iii] a person found to be unfit to stand trial may face indefinite detention, or a period of detention well above the maximum sentence for an offence[102] as these laws can lead to a person pleading guilty to charges for crimes they have not committed simply to avoid the possibility of indefinite detention.[103] Even in jurisdictions with nominal custodial terms,[iv] a person found to be unfit to stand trial may face indefinite or prolonged detention if they are found to be a continued risk to themselves or the public during the review process that takes place on completion of their nominal custodial term.[104] In February 2021, across NSW adult prisons 63 forensic patients were being held in mental health facilities in mainstream prisons, with some having been held in these facilities for decades.[105] Extended periods of confinement and inadequate health care and support can compound pre-existing conditions. Adult and youth prisons are ill-

[iii] Jurisdictions with custodial supervision regimes that operate on an indefinite detention model include Queensland, Western Australia and Tasmania.

[iv] Jurisdictions with custodial supervision regimes that operate on nominal detention models include Victoria and Northern Territory.

suited for the ongoing care and supervision of people with mental illness or cognitive or psychosocial disability, particularly for those with complex support needs.

Continuity of care

The provision of healthcare in prisons should be of a quality equal to that which is provided to the rest of the community, this includes access to Aboriginal Controlled Community Health Organisations (ACCHOs). ACCHOs are best placed to provide holistic and culturally appropriate continuity of healthcare to First Nations people in prisons.[106] The continuity of holistic health care provided by an ACCHO in the community is disrupted when that ACCHO is prevented from accessing a client while they are in prison.[107] The research shows that there are limited opportunities for ACCHOs to deliver health care services to individuals in prisons.[108] These limitations are most commonly attributed to the lack of access to prisoners resulting from security protocols and attitudes of prison staff, and the absence of a sustainable funding model.[109]

Justice Health are responsible for reviewing the provision of health services provided to First Nations people in prisons, including the involvement of ACCHOs[110] and the exchange of relevant health information between prison medical staff and ACCHOs.[111] A recent audit of NSW adult prisons found that Justice Health has limited arrangements with ACCHOs to ensure continuity of care is provided to First Nations people upon their release from prison.[112] The audit also found that Justice Health uses multiple information management systems and that these do not effectively transfer patient records and appointment information when patients are moved across the prison system.[113]

Deaths in Custody

Since the 1991 RCIADIC, at least 495 First Nations people have died in custody,[114] and contrary to the recommendations, the number of First Nations people in prisons has more than doubled.[115] Additional to the Recommendations from the RCIADIC, there have been numerous reports and inquiries by human rights bodies, First Nations organisations and successive governments relating to the over-imprisonment of First Nations people,[116] without meaningful action or improvement of circumstances.

Healthcare provision within the prison system is inadequate, irrespective of geographic division. It is well documented that First Nations individuals are over-imprisoned, at a rate disproportionate to the rest of the population and are put at an unacceptable risk of death or harm in custody due to a lack of cultural safety, inadequate supervision and inadequate healthcare.

The sub-standard healthcare within prisons, and the lack of cultural safety afforded to First Nations individuals within that system, is one of many contributing factors to the unacceptably high rate of First Nations deaths in custody. First Nations people continue to die in custody without accountability, without answers, and without justice.[v] The RCIADIC noted that "adequate post death investigations have the potential to save lives".[117] However, while Coroners have the capacity to make recommendations to ensure deaths are prevented, it is not mandated in the *Coroner's Act 2009* (NSW) ('*Coroner's Act*') that

[v] For a detailed overview of First Nations deaths in custody, please see the NJP's 'Submission to the Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody', August 2020.

investigations of First Nations death in custody consider the quality of care, treatment and supervision and the lawfulness of the custody before their death. While section 82 of the *Coroner's Act* allows discretion in providing recommendations that relate to public health and safety, this does not guarantee that coroners will look into the detainee's life prior to their death,[118] with coroners continuing to confine their investigations in a seemingly deliberate attempt to avoid addressing systemic issues.[119] If system wide changes are not made to the coronial system, First Nations deaths in custody will not be prevented.

Genuine accountability for wrongdoing is critical for deterring future conduct and in providing justice for families of First Nations people who have died at the hands of police and in custodial environments. While Coroners have the power to refer individuals to prosecutors or disciplinary bodies, this rarely occurs.[120] Police and corrective services retain a significant role in coronial inquests and are generally responsible for the initial fact-finding investigation.[121] No Australian jurisdiction has established a system for a completely independent investigation into deaths in police custody.[122] This lack of independence has led to mistrust in the system by First Nations families seeking answers and justice.[123]

Human Rights Framework

Australia's obligations under international law

The right to the highest attainable standard of physical and mental health, and the responsibility of governments to ensure access to medical care for their people, is enshrined in international law.

Article 25.1 of the *Universal Declaration of Human Rights* affirms that "[e]veryone has the right to a standard of living adequate for the health and well-being of [themselves and their] family, including food, clothing, housing and medical care… and disability".[124]

The *International Covenant on Economic Social and Cultural Rights* (ICESCR) provides the most comprehensive article on the right to health in international human rights law in article 12.1 which recognises "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[125] The Committee on Economic, Social and Cultural Rights (CESCR Committee) makes it clear that: "the right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, [and] the prohibition against torture".[126]

The *Declaration on the Rights of Indigenous Peoples* (UNDRIP)[127] specifically recognises First Nations peoples' "equal right to the enjoyment of the highest attainable standard of physical and mental health" in article 24.2.[128] The UNDRIP also recognises First Nations peoples' right to "life, physical and mental integrity, liberty and security of person" in article 7.1.,[129] and the right to self-determination in article 7.2., which states that: "Indigenous peoples have the collective right to live in freedom, peace and security as distinct peoples and shall not be subjected to any act of genocide or any other act of violence, including forcibly removing children of the group to another group".[130]

The CESCR Committee makes it clear that healthcare must be "respectful of medical ethics and culturally appropriate" and designed in a manner to "improve the health status of those concerned".[131] The CESCR Committee also recognises First Nations peoples' right to equitable healthcare through "specific measures"

designed to improve access to healthcare services and supports in a manner that is "culturally appropriate", and makes it clear that states are responsible for providing funding and supports to facilitate First Nations-led design, delivery and control over such services.[132]

The *Convention on the Rights of the Child* (CRC), recognises that all children have the right to enjoy "the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health" in article 24.[133] This right is extended to children living with disabilities in article 23[134] and asylum seeker and refugee children under article 22(1).[135]

The right to healthcare free from racial or gender-based discrimination is recognised in article 5(e)(iv) of the *Convention on the Rights of Persons with Disabilities* (CERD)[136] and in article 12 of the *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW).[137] Read in conjunction, articles 14.1 and 14.2(b) of the CEDAW specifically notes the importance of ensuring that women living in rural areas have access to adequate health care facilities. This is particularly relevant for First Nations people, asylum seekers and refugees and people with disability living in non-metropolitan areas where the intersections of race, gender and disability discrimination has compounding impacts on women, their families and communities in accessing adequate healthcare resulting in harmful and at times fatal outcomes.

The CESCR Committee also details the obligations of state parties to respect the right to health, particularly for "prisoners or detainees, minorities, asylum-seekers and illegal immigrants, to preventative, curative and palliative health services" and to abstain from enforcing discriminatory practices.[138] This Committee is clear that this right is violated by denying "access to health facilities, goods and services to particular individuals or groups as a result of de jure or de facto discrimination".[139]

The United Nations 2030 Agenda for Sustainable Development includes 17 Sustainable Development Goals (SDG), including goal 3 obligating governments to "ensure healthy lives and promote well-being for all at all ages". Specific to health justice, goal 3.4 aims to "reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being" and goal 3.8 aims to achieve universal "access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all".[140]

Obligations under Australian law

Australia has agreed to be bound by a series of international human rights treaties, optional protocols and reporting and communications obligations,[141] which set out in clear terms Australia's international human rights obligations. Under international law, Australia is bound to comply with their provisions and to implement them domestically.[vi, 142] However, they do not form part of Australia's domestic law unless the treaties have been specifically incorporated into Australian law through legislation.[143]

[vi] Section 51(xxix) of the Australian Constitution, the 'external affairs' power, gives the Commonwealth Parliament the power to enact legislation that implements the terms of those international agreements to which Australia is a party.

Australia is a party to all the aforementioned treaties,[vii] meaning that it has agreed to be bound by their provisions. Several rights have made it into domestic law at the federal level, including the *Racial Discrimination Act 1975* (*Cth),* the *Sex Discrimination Act 1984* (*Cth),* the *Australian Human Rights Commission Act 1986* (*Cth),* the *Disability Discrimination Act 1992* (*Cth),* the *Age Discrimination Act 2004* (*Cth),* and at state and territory levels, including the *Human Rights Act 2004 (ACT), Charter of Human Rights and Responsibilities Act 2006 (Vic)* and the *Human Rights Act 2019 (Qld).* The principles can also be found in common law.

Significantly, Australian does not have a Bill of Rights in our Constitution. In the absence of Constitutional protections, the safeguards against human right violations provided in domestic legislation remain susceptible to override by the legislature and the courts continue to be denied power to deprive legal validity to legislation that contravene their terms.

[vii] Australia is also a party to the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, the *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, the *1967 Convention relating to the Status of Refugees* and the *1967 Protocol relating to the Status of Refugees*.

ADDITIONAL RESOURCES

- Igniting Change interview - George Newhouse with Dan Mori (2022).*
- Igniting Change interview - George Newhouse with Kon Karapanagiotidis (ASRC) (2022).
- Submission to the Special Rapporteur on violence against women, its causes and consequences (2022).
- Submission to the Australian Human Rights Commission National Anti-Racism Framework (2022).*
- Submission to the Queensland Parliament Community Support and Services Committee - Criminal Law (Raising the Age of Responsibility) Amendment Bill 2021 (2021).
- Submission to NSW Select Committee's Inquiry into the Coronial Jurisdiction in New South Wales (2021).
- Submission to the Australian Law Reform Commission: Judicial Impartiality Inquiry (2021).
- Submission to the NSW Law Reform Commission - Open Justice Review (2021)
- Health Inquiry into Health Outcomes and Access to Health and Hospital Services in rural, regional, and remote New South Wales (2021).
- Law Hack 2021: Disability Justice Final Report (2021).
- Law Hack 2021: Disability Justice Kick-Off Event (2021).
- Law Hack 2021: Disability Justice Pitch Event (2021).
- Submission to the United Kingdom Parliamentary Committee scrutinising the Nationality and Borders Bill (2021).
- Submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability Submission on laws, policies and practice affecting migrants, refugees and citizens from culturally and linguistically diverse backgrounds (2021).
- Submission to the NSW Select Committee on the High Level of First Nations People in Custody Oversight and Review of Deaths in Custody, Oversight and Review of Deaths in Custody
- (2020).
- Submission to the NSW Civil and Administrative Tribunal Statutory Review (2019).

* Publication pending.

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